

Division of Licensing and Protection

HC 2 South, 280 State Drive

Waterbury, VT 05671-2060

<http://www.dail.vermont.gov>

Survey and Certification Voice/TTY (802) 241-0480

Survey and Certification Fax (802) 241-0343

Survey and Certification Reporting Line: (888) 700-5330

To Report Adult Abuse: (800) 564-1612

March 30, 2017

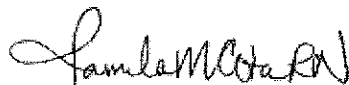
Ms. Mary Jensen, Manager
Wintergreen Residential Care Home
3 Union Street
Brandon, VT 05733-1127

Dear Ms. Jensen:

Enclosed is a copy of your acceptable plans of correction for the survey conducted on February 21, 2017. Please post this document in a prominent place in your facility.

We may follow-up to verify that substantial compliance has been achieved and maintained. If we find that your facility has failed to achieve or maintain substantial compliance, remedies may be imposed.

Sincerely,



Pamela M. Cota, RN
Licensing Chief



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FORM APPROVE

Division of Licensing and Protection

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 0593	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____		(X3) DATE SURVEY COMPLETED C 02/21/2017
NAME OF PROVIDER OR SUPPLIER WINTERGREEN RESIDENTIAL CARE HOME			STREET ADDRESS, CITY, STATE, ZIP CODE 3 UNION STREET BRANDON, VT 05733		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE	
R100	Initial Comments: An unannounced, on-site complaint investigation was conducted by the Division of Licensing and Protection on 02/21/2017. State regulatory violations were identified and the specifics are as follows:	R100			
R127 SS=G	V. RESIDENT CARE AND HOME SERVICES 5.5 General Care 5.5.b Staff shall provide care that respects each resident's dignity and each resident's accomplishments and abilities. Residents shall be encouraged to participate in their own activities of daily living. Families shall be encouraged to participate in care and care planning according to their ability and interest and with the permission of the resident. This REQUIREMENT is not met as evidenced by: Based on medical record review, observations and staff interviews, the community care home failed to assure that 1 of 3 sampled residents was provided care that respected the resident's dignity. (Resident # 1). See below: Per medical record review on 2/21/2017, Resident # 1 was admitted to the community care home on 06/07/2014 with impaired cognition, long standing right calf ulcer, atrial fibrillation and history of a heart attack. The medical record further indicates that Resident # 1 had returned to the home on 2/7/2017 following a 2/3/2017 hospitalization for a decline in his/her overall status. On the morning of 2/3/2017, a nurse from home health arrived, as scheduled, to change	R127	The action taken to correct this deficiency was terminating the two employees involved with the incident. We will also continue to educate current and all future employees about providing care to the residents and respecting their dignity. The measures put into place, so this doesn't recur are, at each shift change both employees are to check each resident together for re-assurance of safety, clean and dry. They will have to sign		

Division of Licensing and Protection

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

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R127-R224 POC accepted 3/30/17 G Coleman/rme

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R127	Continued From page 1 the dressing on Resident # 1 leg and found him/her slumped over in a chair, having been incontinent of stool. Staff reported that they were unable to stand Resident # 1 in order to clean him/her and so "wiped up around as best they could." Staff report that this was noticed during rounds at 3:00 am and that no one was notified to come to assist the staff member on duty. Resident # 1 was left in this condition until the home health nurse arrived at 11:00 am. Administration reports that at the change of shift when more personnel are available, Resident # 1 was not cleaned and or moved into bed. On 2/8/2017 Resident # 1 was seen in the hospital emergency room for elevated blood pressures, as taken by the staff at the home. S/he was evaluated in the emergency room and returned to the home until 2/17/2017 when s/he was brought back to the hospital. There are no assessments done at this time to indicate a change in the condition of Resident # 1 or that his/her needs were exceeding the abilities of the community care home.	R127	off before they leave or start the next shift that all residence are clean and safe. If help with a resident is needed at shift change they are to stay until the situation is all taken care of. Corrective measures will be monitored daily by the manager. Corrective action will be completed by 3/1/17	
R136 SS-D	V. RESIDENT CARE AND HOME SERVICES 5.7. Assessment 5.7.c Each resident shall also be reassessed annually and at any point in which there is a change in the resident's physical or mental condition. This REQUIREMENT is not met as evidenced	R136	m	

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NAME OF PROVIDER OR SUPPLIER

STREET ADDRESS, CITY, STATE, ZIP CODE

WINTERGREEN RESIDENTIAL CARE HOME

3 UNION STREET
BRANDON, VT 05733

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
R136	<p>Continued From page 2</p> <p>by: Based on medical record review and staff interviews, the community care home failed to assure that 1 of 3 residents was properly assessed after a change in his/ her physical status. (Resident # 1). See below for specific details:</p> <p>Per medical record review on 2/21/2017, Resident # 1 was admitted to the community care home on 06/07/2014 with impaired cognition, long standing right calf ulcer, atrial fibrillation and history of a heart attack. The medical record further indicates that Resident # 1 had returned to the home on 2/7/2017 following a 2/3/2017 hospitalization for a decline in his/ her overall status. On the morning of 2/3/2017, a nurse from home health arrived, as scheduled, to change the dressing on Resident # 1 leg and found him/ her slumped over in a chair, having been incontinent of stool. Staff reported that they were unable to stand Resident # 1 in order to clean him/ her and so "wiped up around as best they could." Staff report that this was noticed during rounds at 3:00 am and that no one was notified to come to assist the staff member on duty. Resident # 1 was left in this condition until the home health nurse arrived at 11:00 am. Administration reports that at the change of shift when more personnel are available, Resident # 1 was not cleaned and or moved into bed. Prior to this Resident # 1 was able to ambulate using a walker.</p> <p>There are no assessments done at this time to indicate a change in the condition of Resident # 1.</p> <p>The home's nurse and director confirm during interview that there were no assessments to</p>	R136	<p>The action taken to correct this deficiency is to update any assessments including Resident #1 that has had any physical or mental change in their status.</p> <p>The measures that will be put into place so this does not recur are, a reminder posted at the RN desk to reassess if changes occur with a resident or a resident is hospitalized</p> <p>The corrective measures will be monitored by the manager every 2 weeks, and as needed.</p> <p>Corrective action will be completed by 3/1/17</p>	

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R136	Continued From page 3 indicate a change in the physical status of Resident # 1.	R136			
R147 SS=E	<p>V. RESIDENT CARE AND HOME SERVICES</p> <p>5.9.c (4)</p> <p>Maintain a current list for review by staff and physician of all residents' medications. The list shall include: resident's name; medications; date medication ordered; dosage and frequency of administration; and likely side effects to monitor;</p> <p>This REQUIREMENT is not met as evidenced by: Based on medical record reviews and staff interviews, the community care home failed to include parameters for the use of analgesics for 3 of 3 sampled residents, (Resident # 1, # 2 and # 3). The specifics are detailed below:</p> <p>Per record review of Residents # 1, # 2 and # 3, there are no parameters listed on which medication to choose for pain relief. All have standing orders that read:</p> <ol style="list-style-type: none"> 1) Tylenol 325 mg 2 by mouth every 6 hours as needed for pain or fever; 2) Ibuprofen 200 mg by mouth every 6 hours as needed for pain or 3) Extra Strength Tylenol 2 tabs every 4 hours for generalized discomfort/ malaise <p>The med delegation program is for personal care attendants to give medications but there are no guidelines for them to know which pain medication to choose. The home's nurse</p>	R147	<p>The action taken to correct this deficiency is the RN reviewed the residents Medical records and set up guidelines for the P.C.A to ensure which Pain medication to use.</p> <p>The measures put into place so this doesn't recur again is the P.C.A will have more training with the R.N. and the RN will include parameter for the use of analgesics.</p> <p>Corrective actions will be monitored by the R.N. to ensure the deficient practice doesn't recur.</p> <p>Corrective action will be completed by 3/1/17</p>		

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R147	Continued From page 4 confirms this during a telephone interview at 1:30 PM.	R147			
R189 SS=D	<p>V. RESIDENT CARE AND HOME SERVICES</p> <p>5.12.b. (3)</p> <p>For residents requiring nursing care, including nursing overview or medication management, the record shall also contain: initial assessment; annual reassessment; significant change assessment; physician's admission statement and current orders; staff progress notes including changes in the resident's condition and action taken; and reports of physician visits, signed telephone orders and treatment documentation; and resident plan of care.</p> <p>This REQUIREMENT is not met as evidenced by: Based on medical record review and staff interviews, the community care home failed to have an updated assessment after a significant change in physical status for 1 of 3 residents in the sample. (Resident # 1). The specifics are detailed below:</p> <p>Per medical record review on 2/21/2017, Resident # 1 was admitted to the community care home on 06/07/2014 with impaired cognition, long standing right calf ulcer, atrial fibrillation and history of a heart attack. The medical record further indicates that Resident # 1 had returned to the home on 2/7/2017 following a 2/3/2017 hospitalization for a decline in his/ her overall status.</p> <p>On 2/8/2017 Resident # 1 was seen in the</p>	<p>R189</p> <p>The action taken to correct this deficiency is the RN updated the assessment on Resident #1 for a significant change in physical status.</p> <p>The measures put into place so this doesn't recur is, the RN will communicate with P.C.A. weekly in reference to residents changes and/or concern. Staff continues to write in residents charts on current physical & mental status. R.N. continues to read through charts to stay updated on all residents status.</p> <p>Corrective actions will be monitored weekly by the R.N.</p> <p>Corrective actions will be completed by 3/1/17</p>			

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R189	Continued From page 5 hospital emergency room for elevated blood pressures, as taken by the staff at the home. S/he was evaluated in the emergency room and returned to the home until 2/17/2017 when s/he was brought back to the hospital. The last assessment for Choices for Care is dated 6/1/2016 through 5/31/2017. There are no assessments done prior to hospitalization or upon his/ her return to the home to indicate a change in the condition of Resident # 1. The home's nurse and director both confirm, during interview, that no assessments are documented as having been done after a significant change in his/ her and decline in overall status.	R189			
R207 SS=D	V. RESIDENT CARE AND HOME SERVICES 5.18 Reporting of Abuse, Neglect or Exploitation 5.18.b The licensee and staff are required to report suspected or reported incidents of abuse, neglect or exploitation. It is not the licensee's or staff's responsibility to determine if the alleged incident did occur or not; that is the responsibility of the licensing agency. A home may, and should, conduct its own investigation. However, that must not delay reporting of the alleged or suspected incident to Adult Protective Services. This REQUIREMENT is not met as evidenced by: Based on medical record review, staff interviews and the internal home's investigation, the community care home failed to report a suspected incident of neglect for 1 of 3 residents.	R207	The action taken to correct this deficiency is RN posted the A.P.S. phone number to call when there's an incident of suspicion or alleged. Training for current & future employees, along with more communication between RN, managers, staff in reference to residents' overall care and health. The measures that are put into		

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NAME OF PROVIDER OR SUPPLIER

STREET ADDRESS, CITY, STATE, ZIP CODE

WINTERGREEN RESIDENTIAL CARE HOME

3 UNION STREET
BRANDON, VT 05733

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R207

Continued From page 6

(Resident # 1.) The specifics are detailed below:

Per staff interview on 2/21/2017, the home failed to notify the regulatory agency or the resident's physician of an episode of suspected neglect for Resident # 1. The home staff report, during interview, that they thought that the report made by the home health nurse to APS (Adult Protective services was all the reporting that needed to be done.) They confirm that they did not make any notifications about a resident left uncleaned for over 8 hours.

R224
SS=G

VI. RESIDENTS' RIGHTS

6.12 Residents shall be free from mental, verbal or physical abuse, neglect, and exploitation. Residents shall also be free from restraints as described in Section 5.14.

This REQUIREMENT is not met as evidenced by:

Based on medical record review and staff interviews, the community care home failed to assure that 1 of 3 residents was free from neglect. (Resident # 1). The specifics are detailed below:

Per medical record review on 2/21/2017, Resident # 1 was admitted to the community care home on 06/07/2014 with impaired cognition, long standing right calf ulcer, atrial fibrillation and history of a heart attack. The medical record further indicates that Resident # 1 had returned to the home on 2/7/2017 following a 2/3/2017 hospitalization for a decline in his/ her overall status. On the morning of 2/3/2017, a nurse from

R207

Place are more extensive training about what can be or is neglect, abuse or exploitation. Staff will immediately call RN, manager if they are unsure.

Corrective actions will be monitored by manager daily along with all new employees training packet.

Corrective actions will be completed by 3-1-17

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INTERGREEN RESIDENTIAL CARE HOME

3 UNION STREET
BRANDON, VT 05733

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R224	Continued From page 7 home health arrived, as scheduled, to change the dressing on Resident # 1 leg and found him/her slumped over in a chair, having been incontinent of stool. Staff reported that they were unable to stand Resident # 1 in order to clean him/her and so "wiped up around as best they could." Staff report that this was noticed during rounds at 3:00 am and that no one was notified to come to assist the staff member on duty. Resident # 1 was left in this condition until the home health nurse arrived at 11:00 am. Administration reports that at the change of shift when more personnel are available, Resident # 1 was not cleaned and or moved into bed. This was confirmed by the Director of the home during interview in the afternoon and by documentation of the home's internal investigation.	R224	<p>The action taken to correct this deficiency is all staff and all shifts are to continue to check residents every hour and check each resident at shift change to ensure residents are clean, dry & safe. Staff signs off on a sheet stating all residents are in good condition and the employees are to stay and help w/ residents when needed.</p> <p>The measures put into place are two employees are checking on all residents before the next shift starts so there's no excuse for any resident being neglected.</p> <p>The manager will check and monitor if these checks are being completed daily.</p> <p>Corrective action will be completed by 3-1-17</p>	